

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6965 CERTIFICATE OF DEATH

06935
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hardey Street</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN TB <i>39 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hardey Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>811 Miles</i>	
3. NAME OF DECEASED (Type or print) <i>William J. Cusabish</i>		4. DATE OF DEATH <i>6/11/60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/9/1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Engin. Penn. R.R.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. AGE (In years last birthday) <i>77 yrs.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		13. FATHER'S NAME <i>Emmanuel Cusabish</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Loft</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or dates of service) <i>Unknown</i>	
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>James Cusabish, Claude Gause</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cardiac decompositi Active sebaceous hidradenitis Feb to June INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> , 1960, to <i>June 11, 1960</i> , that I last saw the deceased alive on <i>June 11, 1960</i> , and that death occurred at <i>Liberty</i> , from the causes and on the date stated above. ADDRESS (Street, city, or town, state) DATE SIGNED ACTUAL SIGNATURE <i>E. J. Simon</i> M.D. <i>Hardey Street, 2d</i>			
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>6/14/60</i>		22b. DATE THEREOF <i>6/14/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mr. Oliver</i>		22d. LOCATION (City, town, or county) <i>Washington D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paragonium</i>		ADDRESS <i>Hardey Street, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUN 16 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

18

THE STATE GOVERNMENT OF HENRY - SALTIMBOCH

CERTIFICATE OF DEATH

1 B
M
071
B
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6966

CERTIFICATE OF DEATH

06936

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md CECIL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harde-Grace		c. LENGTH OF STAY IN 1b TWO Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. STREET ADDRESS R.F.D.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harry	Middle	Last Baker	4. DATE OF DEATH	Month 4	Day 20	Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Tenant Farmer		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Baker		14. MOTHER'S MAIDEN NAME Leah Jackson				Address Washington 442 Ottawa St. 21, D.C.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-3554		17. INFORMANT W. H. Baker		INTERVAL BETWEEN ONSET AND DEATH 1 month 8 yrs		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) DUE TO (c)		Chronic Heart Failure Chronic Myocarditis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Arterio-Sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Port Deposit, Md.		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1960</u> to <u>June 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1960</u> and that death occurred on <u>June 20, 1960</u> M, from the causes and on the date stated above.								
22a. SIGNATURE Clarence I. Benson, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 21-1960		
22c. PHYSICIAN'S NAME (Type)		Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.				
23a. BURIAL, CREMATION, ETC. Burial		23b. DATE THEREOF 6-23-1960		23c. NAME OF CEMETERY OR CREMATORIAL Asbury		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural		
24. FUNERAL DIRECTOR'S SIGNATURE Lie a. Patterson & Son,		ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR JUN 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SEARCHED

2303

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06937

6967

1. PLACE OF DEATH
a. COUNTY

HARFORD

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

24 HARVE DE GRACE

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HARVE DE GRACE

c. LENGTH OF STAY IN 1b

30 min

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

HARFORD MEMORIAL HOSP

d. STREET ADDRESS

715 Polaski Hwy

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

MALE

6. COLOR OR RACE

wh.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Aug 19, 1918

9. AGE (In years
lost birthday)

41 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

INSURANCE AGENT

10b. KIND OF BUSINESS OR INDUSTRY

INSURANCE

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Blumberg

14. MOTHER'S MAIDEN NAME

Bessie ISRAEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

DR. WOLBERT.

17. INFORMANT

Address

H. d. Grace Ind.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)420.1
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

Acute Pulmonary Edema

INTERVAL BETWEEN
ONSET AND DEATH

10 minutes

(b)

Coronary occlusion -

DUE TO

Anemia Pectoris.

5 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 1920d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

June 1938 to June 7, 1960, that (I) (we) last
saw the deceased alive on June 7, 1960, and that death occurred at 2 AM, from the causes and on the date stated above.

22a. SIGNATURE

Frank Wolbert M.D.

ATTENDING
PHYS.MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
June 7, 196022c. PHYSICIAN'S
NAME (Type)

FRANK WOLBERT M.D.

22d. ADDRESS

Hause de Grace Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

6/8/60

23c. NAME OF CEMETERY OR CREMATORIUM

MISHKIN ISRAEL CONG.

23d. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.

ADDRESS

25a. REC'D BY REGISTRAR

JUN 10 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6958

CERTIFICATE OF DEATH

66938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Edmund Street		d. STREET ADDRESS 103 Edmund Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First EDNA	Middle WALTER	4. DATE OF DEATH Lost BUDNICK June 26 Month Doy Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1878			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home				
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Oliver Walter		14. MOTHER'S MAIDEN NAME Catherine Scarborough				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT F. Hollis Budnick Aberdeen, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO Myocardial Infarction Arterosclerotic Heart Disease Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Terminal 6 mos. 6 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) Aberdeen, Md.	(County)	(State)
21. I certify that I attended the deceased from <u>6-26-1960</u> to <u>6-26-1960</u> , that I last saw the deceased alive on <u>6-26-1960</u> , and that death occurred at <u>9:10 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Aberdeen, Md.						
DATE SIGNED ACTUAL SIGNATURE <u>Peter P. Rodman</u> June 27 1960						
PHYSICIAN'S NAME (Type) Peter P. Rodman M.D. Aberdeen, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/29/60	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul Luthern Cem.	22d. LOCATION (City, town, or county) R.D. Aberdeen, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarring</u>	ADDRESS Tarring Funeral Home Aberdeen, Md.	24a. REC'D BY REGISTRAR JUN 30 '60	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Head</u>			

DEPARTMENT OF HEALTH-ENVIRONMENT STATE OF MARYLAND
CERTIFICATE OF DEATH

DEATH CERTIFICATE

6987

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shawsville		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter		First Herbert	Middle Cairnes	Last 	4. DATE OF DEATH June 18 1960	Month June	Day 18	Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 23, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director & Agent		10b. KIND OF BUSINESS OR INDUSTRY Mutual Insurance Co.		11. BIRTHPLACE (State or foreign country) Jarrettsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Andrew Cairnes		14. MOTHER'S MAIDEN NAME Cornealia Haile							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-3721		17. INFORMANT Mrs. Louise Cairnes		Address Jarrettsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH immediate									
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease years DUE TO (c)									
DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no accident or injury							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none		(County) none	(State) none
21. I certify that I attended the deceased from Sept. 2, 1959 , to June 18, 1960 , that I last saw the deceased alive on June 6, 1960 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Jarrettsville, Maryland									DATE SIGNED June 18, 1960
ACTUAL SIGNATURE <i>James F. White, Jr.</i>		M.D. Houcks Mill Road							
PHYSICIAN'S NAME (Type) James F. White, Jr. M.D.		Jarrettsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/1960		22c. NAME OF CEMETERY OR CREMATORIAL Bethel		22d. LOCATION (City, town, or county) Madonna			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Rusty</i>		ADDRESS Jarrettsville, Maryland		24a. REC'D BY REGISTRAR JUN 21 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06940

Reg. Dist. No.

M

6988

1. PLACE OF DEATH
a. COUNTY

Hayford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bel Air

c. LENGTH OF STAY IN lb

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Thomas Run Road + Kalmia Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md

b. COUNTY

Hayford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bel Air

32

d. STREET ADDRESS

Thomas Run Road + Kalmia Rd.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First Anthony C.

Middle

Last

4. DATE
OF
DEATHJune Month
16Day Year
1960

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

JAN. 19, 1957

9. AGE (In years
last birthday)

3

yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William L. Clarke Jr.

14. MOTHER'S MAIDEN NAME

Norma Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

—

17. INFORMANT

William L. Clarke Jr., Bel Air, Maryland

120 #1 Address

Box 393

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

929.8

DUE TO

Conditions, if any, which
goe rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell into farm pond

20c. TIME OF INJURY

Month, Day, Year

Hour o. m. 6-16 1960

20d. INJURY OCCURRED

While

Not while

at work

STATE OF NEW YORK
DEPARTMENT OF MOTOR VEHICLES
VEHICLE EXAMINER'S CERTIFICATE OF REPAIR

Vehicle
Number

1978-1981

1982-1985

1986-1989

1990-1993

1994-1997

1998-2001

2002-2005

2006-2009

2010-2013

2014-2017

2018-2021

2022-2025

2026-2029

2030-2033

2034-2037

2038-2041

2042-2045

2046-2049

2050-2053

2054-2057

2058-2061

2062-2065

2066-2069

2070-2073

2074-2077

2078-2081

2082-2085

2086-2089

2090-2093

2094-2097

2098-20101

20102-20105

20106-20109

20110-20113

20114-20117

20118-20121

20122-20125

20126-20129

20130-20133

20134-20137

20138-20141

20142-20145

20146-20149

20150-20153

20154-20157

20158-20161

20162-20165

20166-20169

20170-20173

20174-20177

20178-20181

20182-20185

20186-20189

20190-20193

20194-20197

20198-20201

20202-20205

20206-20209

20210-20213

20214-20217

20218-20221

20222-20225

20226-20229

20230-20233

20234-20237

20238-20241

20242-20245

20246-20249

20250-20253

20254-20257

20258-20261

20262-20265

20266-20269

20270-20273

20274-20277

20278-20281

20282-20285

20286-20289

20290-20293

20294-20297

20298-20299

20300-20301

20310-20311

20312-20313

20314-20315

20316-20317

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1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death.
 the State Board of Health prior to burial, cremation or removal, and in any case within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 6968 CERTIFICATE OF DEATH

06941

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md				
Dayford				b. COUNTY		Dayford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
RURAL and give nearest town Havre de Grace				3) Aberdeen						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
Dayford Memorial Hospital		354 Carter St								
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year		
Jesse		B.	Clifton	Lost	June 24	1960				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 16, 1890	71 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Retired Machisist. U.S. Govt.				T.C.		U.S.				
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME								
Samuel Clifton		Deceased								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		226-05-1633		Joy Clifton - wife		same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										1 day
434.4 DUE TO Pulmonary Hemorrhage										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Bronchial Asthma										
C (c) DUE TO Cor Pulmonale										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19										
21. I certify that (I) (this hospital) attended the deceased from January 1958 to June 24, 1960, that (I) (we) last saw the deceased alive on June 24, 1960, and that death occurred at 2 PM, from the causes and on the date stated above.										
22a. SIGNATURE										22b. DATE SIGNED 6/24/60
Irvin Wachsman, M.D.										
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS								
Irvin Wachsman, M.D.		407 S. Union Ave. Havre de Grace, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town, or county)		(State)		
Burial		6/27/60		Bakers Cemetery		RD. Aberdeen,		Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE		Tarring		Funeral Home		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John G. Tarring				Aberdeen, Md.		DATE JUN 28 '60		Arthur S. Kraus		
John G. Tarring										

WABO-STADION 1982

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

66942

6969

CERTIFICATE OF DEATH

66942

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. STREET ADDRESS 1331 S. Union Ave.	
3. NAME OF DECEASED (Type or print) Theresa		First R	Middle DeLP
4. DATE OF DEATH Month June Day 22 Year 1960		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH June 20, 1960		9. AGE (In years lost birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leifant		10b. KIND OF BUSINESS OR INDUSTRY Leifant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Olan Roy DeLP		14. MOTHER'S MAIDEN NAME Alice Ernestine Ashby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Olan R. DeLP - 1331 S. Union Ave. Md.		Address Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage (Subarachnoid)			
DUE TO (b) Prematurity			
DUE TO (c) —			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
B. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Premature labor.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20, 1960 to June 22, 1960 that (I) (we) last saw the deceased alive on June 22, 1960 and that death occurred at 115 M. from the causes and on the date stated above.			
22a. SIGNATURE William M. LEEN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William M. LEEN		22d. ADDRESS 600 S. Union Ave. Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal.		23b. DATE THEREOF 6/23/60	
23c. NAME OF CEMETERY OR CREMATORIAL Huffman Family Cemetery		23d. LOCATION (City, town, or county) (State) Princeton, R.O. #1 - W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrung Aberdeen, Md.		ADDRESS —	
25a. REC'D BY REGISTRAR Arthur S. Thomas		DATE JUN 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

54000

THE STATE OF PENNSYLVANIA

PLATE 50 PLATE 50 PLATE 50 PLATE 50 PLATE 50 PLATE 50

2300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6970

CERTIFICATE OF DEATH

06943

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Harford		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harpe-de-Grace		c. LENGTH OF STAY IN 1b 3 1/2 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS Main ST.	
Carl		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1900	
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard H. Goodman		14. MOTHER'S MADDEN NAME Dora Johnston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Yes W. War 11 216-20-2276	
17. INFORMANT Elmer Reedy, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 42 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-10 1960 to 6-10 1960, that (I) (we) lost saw the deceased alive on 6-10 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE G. H. Richards Jr. M.D.		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, Baptist		23b. DATE THEREOF 6-13-1960	
23c. NAME OF CEMETERY OR CREMATORIAL Conowingo Baptist		23d. LOCATION (City, town, or county) Conowingo, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Perry Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06944

1. PLACE OF DEATH 6971
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood Rural,
d. STREET ADDRESS Box 622 (Van Bibber)

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
(Type or print) VIRGIE M. HARRIS 6 1 19 60

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) 10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.
Female White WIDOWED DIVORCED Feb. 25, 1909 50 Months Deys Hours Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Gas Mask Assembler U.S. Govt., Virginia U.S.A.,

13. FATHER'S NAME Melvin Tiller 14. MOTHER'S MAIDEN NAME Nora Mc Fadden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
(Yes, no, or unknown) (If yes give rank or dates of service) 213-16-9314 Luther Harris Edgewood, R.D., Md.,

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: Address
IMMEDIATE CAUSE (e) Crushing injury of chest.
no
816X
DUE TO
Conditions, any, which
gave rise to immediate cause
(e), stealing the underlying
cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTO PERFORMED
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20d. INJURY OCCURRED While Not While
at work at work Highway Edgewood Harford Md.

20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. 1:15 P.m. 6/1 19 60

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER
ACTUAL SIGNATURE Wm. J. Stoddard M.D. ASSISTANT MEDICAL EXAMINER
EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER
Address (Street, city, town, or county) DATE SIGNED
June 2, 1960

22e. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or country) (State)
Burial June 5, 1960 Cokesbury Memorial Abingdon, Harford, Md.,

23. FUNERAL DIRECTOR ADDRESS 24e. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
Howard N. McCormick, Jr. Abingdon, Md., DATE JUN 6 '60 Oliver S. Krause

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6960

CERTIFICATE OF DEATH

06945

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Front St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Blaine G		First	Middle	Last	4. DATE OF DEATH June 17 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH February 25, 1881	9. AGE (in years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad employee		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Hartenstine		14. MOTHER'S MAIDEN NAME Sarah R. Jackson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Melvin Hartenstine, Perryville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Hepatic Coma, terminating		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO (c) Chronic cirrhosis of the liver		INTERVAL BETWEEN ONSET AND DEATH 48 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchial asthma; Chronic cardio-vascular disease.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic bronchial asthma; Chronic cardio-vascular disease.		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Forest Hill, Maryland		20f. (City or town) (County) (State)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Forest Hill, Maryland		
21. I certify that (I) Willard P. Hudson attended the deceased from June 30, 1959 , to June 17, 1960 , that (I) (W.H.) last saw the deceased alive on June 17, 1960 , and that death occurred at 7:25 A.M. from the causes and on the date stated above.		22a. SIGNATURE Willard P. Hudson, M.D.		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 17, 1960		
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		22d. ADDRESS Forest Hill, Maryland						
23a. BURIAL OR CREMATION, REMAVAL (Specify) Burial		23b. DATE THEREOF 6-19-1960		23c. NAME OF CEMETERY OR CREMATORIUM Principio Cemetery		23d. LOCATION (City, town, or county) (State) Principio Furnace, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE John Patterson & Son		ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans		

MAILED 8/10/68 0803

may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6972

CERTIFICATE OF DEATH

06947

M

071

I

D

1

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MD		b. COUNTY		HARFORD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		32 Forest Hill Bel Air Md.		d. STREET ADDRESS		Forest Hill Rd.	
Harford		16 days		32 Forest Hill Bel Air Md.		Forest Hill Rd.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Harde Grace											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Harford Memorial Hospital		d. STREET ADDRESS		Forest Hill Rd.					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Carl				Henry Henderson	6	10	1960				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.				
Male		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	?	62 yrs.	Months	Days	Hours	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
None		Unknown		Va		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Charlie Henderson		Alice									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Unknown		Unknown		Mrs. Mack Dixon, Prospect Mills, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Failure									
5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO asthma									
		DUE TO hypoxemia									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
				Forest		May 28 1960, to June 10 1960					
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, and that death occurred at _____, from the causes and on the date stated above.											
22a. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		6-10-60	
E. J. Simon											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		Forest		Md.					
E. J. Simon		Forest		Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)			
6/14/60		REEDY		RUGBY		RUGBY		Va.			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. J. Simon, Esq., Harford, Md.				JUN 14 '60		F. J. Simon, Esq., Harford, Md.					

STC3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G263 6-20-60 et

06948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fairford & me</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 18</i>	
d. STREET ADDRESS <i>2726 Tivoli Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mark Spangler Hudson</i>		4. DATE OF DEATH Last <i>58</i> Month <i>June</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-20-10</i>
9. AGE (in years last birthday) <i>49</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Construction Worker</i>	
11. BIRTHPLACE (State or foreign country) <i>Greenwell W. Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wilbur H Hudson</i>		14. MOTHER'S MAIDEN NAME <i>Maria May Carter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Reta Ann Hudson 2726 Tivoli Ave</i>	
17. INFORMANT <i>Reta Ann Hudson 2726 Tivoli Ave</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (d) cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Auto accident auto-object type</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident auto-object type</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>7:30</i> o. m. <i>6-11</i> 19 <i>60</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Fairford Ave Bel Air Harford Md</i>		20f. (City or town) (County) (State) <i>Baltimore, Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		DATE SIGNED <i>6-11-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/15/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Sunset Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald C. Palmer Inc 5305 Harford Rd</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <i>JUN 15 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66949

6973

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. LENGTH OF STAY IN b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE	
3. NAME OF DECEASED (Type or print) AMY ADELAIDE DECKMAN JAMISON		First	Middle
		Last	
4. DATE OF DEATH		Month	Day
		6	7
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 5/22/1879	
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WAKEMAN JOURDAN		14. MOTHER'S MAIDEN NAME MARY M. MITCHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. CONNIE BAKER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 331X (b) cerebral arteriosclerosis DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 6 days 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 , 19 58 to 6/7 , 19 60 , that I last saw the deceased alive on 6/5 , 19 60 , and that death occurred at 6:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 6/7/60	
ACTUAL SIGNATURE Neil Taylor Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 6/10/1960		22c. NAME OF CEMETERY OR CREMATORIAL ROCK RUN CEM.	
22d. LOCATION (City, town, or county) DARLINGTON		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. McManus		ADDRESS RISING SUN, MD.	24a. REC'D BY REGISTRAR DATE JUN 9 '60
		24b. REGISTRAR'S SIGNATURE Charles E. Taylor	

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06950

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please ~~use~~ ~~call~~ the Office. Write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be ~~sent~~ ~~farther~~ to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your ~~use~~ ~~information~~. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		6962 Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY				
Bel Air								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 18 3001.4		
Fulford & ne				d. STREET ADDRESS		3910 S Clair Rd		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Cecil R Jones					June	11	19	60
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
M		W		May 30 1910 50	50 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Miner		Coal Industry		Raleigh, N.C.		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Alphons Jones		Hattie Woods						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
If yes, give war or dates of service)						Alice Jean Jones 3910 S Clair Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 819X DUE TO Fracture Skull INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Auto accident and -abused type								
20c. TIME OF INJURY Hour o. m. 7:30		Month, Day, Year 6-11 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Englewood		20f. (City or town) Bel Air, Harford Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		Bel Air, Md DATE SIGNED 6-11-60		
EXAMINER'S NAME (Type)		Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL PROSPERITY Cem		22d. LOCATION (City, town, or county) Baltimore, Md		(State)
Burial		6/14/60						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR JUN 15 1960		24b. REGISTRAR'S SIGNATURE Anne S. Friend		
Leonard J. Rick, Inc.		5305 Harford Rd		DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22c FilmG265 6-21-60 et

00351

06951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 ALICE ANNE Street		e. STREET ADDRESS 127 ALICE ANNE Street	
3. NAME OF DECEASED (Type or print) NATHAN		First A.	Middle KELL
4. DATE OF DEATH JUNE 15, 1960	Month Day Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Harford Co., Maryland
13. FATHER'S NAME FRANK KELL		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. World War I	17. INFORMANT JOSEPHINE Clark
		16. SOCIAL SECURITY NO. 214-12-3763	17. INFORMANT Address 115 Bond Street Bel Air, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bel Air, Md.	
ACTUAL SIGNATURE Charles Richardson, M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Bel Air View Methodist Cemetery
22d. LOCATION (City, town, or county) Bel Air-Rural, Harford Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		ADDRESS w. Broadway & Williams St. Bel Air, Maryland	24a. REC'D BY REGISTRAR JUN 17 1960
			DATE
			24b. REGISTRAR'S SIGNATURE Joseph W. Foster

CERTIFICATE OF DEATH

DEATH DATE	1981-07-01	TIME	10:00 AM
DEATH PLACE	Home	DEATH CERTIFIED	Yes
DEATH CERTIFIED BY	John Doe	RELATIONSHIP	Spouse
DEATH CERTIFIED BY SIGNATURE		DATE	07/01/81
DEATH CERTIFIED BY			
John Doe			
Spouse			
07/01/81			
Signature			
Date			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974

CERTIFICATE OF DEATH

06952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Game</i>		b. COUNTY <i>Harford</i>		
c. LENGTH OF STAY IN 1b <i>40 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harde Game</i> <i>24</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>724 Erie</i>		
3. NAME OF DECEASED (Type or print) <i>Catherine Langris</i>		First <i>Catherine</i>	Middle <i>Langris</i>	
Last <i>—</i>		4. DATE OF DEATH <i>6/11/60</i>	Month <i>Month</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/19/1885</i>	
9. AGE (In years lost birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours</i>	
13. FATHER'S NAME <i>Paul Comiti</i>	14. MOTHER'S MAIDEN NAME <i>Ida Poliutti</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service) <i>Unknown</i>		
16. SOCIAL SECURITY NO. <i>Unknown</i>			17. INFORMANT <i>Paul Langris 724 Erie St. Harde Game Md.</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Dr. Sama</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420</i> <i>Coronary occlusion</i> (b) DUE TO <i>Chronic Myocarditis</i> (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July</i> , 19 <i>56</i> , to <i>June</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 11, 1960</i> , and that death occurred at <i>20</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Wolbert MD</i> PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT MD</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/15/60</i>		22b. DATE THEREOF <i>6/15/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Erie</i>	22d. LOCATION (City, town, post town) <i>Harde Game Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franklin R. Harde Game Md.</i>		24a. ADDRESS <i>—</i>	24b. REC'D BY REGISTRAR <i>Arthur S. Kline</i>	24c. DATE JUN 14 '60

MANUFACTURE OF THE DEPARTMENT OF NAVY—GALVANIC
COPPER CO. CERTIFICATE OF DESIGN

100-1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

-FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6959

Items 7, 12 Film G265 6-17-60 et

06953

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Harford		a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penna. R.R. Tracks		d. STREET ADDRESS / R.D. #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wasil		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	Unknown
9. AGE (In years last birthday)		10. UNDER 1YEAR	11. UNDER 24 HRS.
Appr. 65 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Industry	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?		Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.-1	17. INFORMANT Chas. B. Osborn Jr. Aberdeen, Md.
Address R.D. 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Complete Body dismemberment	
802 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walked across R.R. tracks & Train struck him.	
20c. TIME OF INJURY Hour 10:00 a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Penna R.R Tracks Aberdeen Harford
20f. (City or town) Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Gerald C. Palmer		DATE SIGNED Baltimore, Md. 6-9-60	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/60	22c. NAME OF CEMETERY OR CREMATORIAL Bakers Cemetery
22d. LOCATION (City, town, or county) R.D. Aberdeen, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		24a. ADDRESS Tarring Funeral Home Aberdeen, Md.	24b. REC'D BY REGISTRAR DATE JUN 14 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
VS. A15ME 5M 2/57			

WISCONSIN STATE BOARD OF EXAMINERS OF TEACHERS
WISCONSIN STATE EXAMINERS OF TEACHERS

692

STATE
TEACHERS

1895-96

1896-97

1897-98

1898-99

1899-1900

1900-1901

1901-1902

1902-1903

1903-1904

1904-1905

1905-1906

1906-1907

1907-1908

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA		c. LENGTH OF STAY IN 1b 9 mos				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 750A ALEXIS Dr., RD#2 JOPPA, Md		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA				
d. STREET ADDRESS Box 750A ALEXIS Dr. RD#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Roy Lockwood	Middle MILLER	Last 4. DATE OF DEATH JUNE 22 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 24 1919			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLWRIGHT		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE				
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME LUTHER CARL MILLER		14. MOTHER'S MAIDEN NAME MARGARET MARIE GRIMES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] NO		16. SOCIAL SECURITY NO. 168-09-5350				
17. INFORMANT Tom MILLER		4 QUINCE LANE BALTIMORE 20, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE CORONARY Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ebensburg	(County) Pa.	(State) Pa.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Philip W. Heuman		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED JUNE 22, 1960		
EXAMINER'S NAME (Type) PHILIP W. HEUMAN M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF June 26, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Lloyd	22d. LOCATION (City, town, or county) Ebensburg, Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS LASSAHN FUNERAL HOME, BALTIMORE, MD		24a. REC'D BY REGISTRAR DATE JUN 24 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06955

6975

CERTIFICATE OF DEATH

Reg. Dist. No.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Havre-de-Grace

c. LENGTH OF STAY IN 1b

2 weeks

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md

b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

31 Aberdeen

d. STREET ADDRESS

1 Monroe St.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
6Day
2Year
1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED 9. AGE (In years
last birthday)

29 yrs.

10. IF UNDER 1 YEAR

Months
2

IF UNDER 24 HRS.

Days
4Hours
0Min.
010a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

House-wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jack Cottman.

14. MOTHER'S MAIDEN NAME

Martha Woodley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)

213-26-6414

INFORMANT

Address
37th Street

Mrs. Martha J. Cottman, deceased, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

580X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cause: yellow citroly liver

INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year
Hour a. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 5/18/60, 1960, to 6/2/60, 1960, that I last saw the deceased alive on 6/2/60, 1960, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE: Irvin L. Wachsman, M.D. Havre de Grace, Md. 6/9/60

PHYSICIAN'S
NAME (Type)

Irvin L. Wachsman, M.D.

Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

Removal

6/6/60

22c. NAME OF CEMETERY OR CREMATORIUM

Little Mount Baptist

22d. LOCATION (City, town, or county) (State)

Sussex County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Elmer E. Bullock Havre de Grace, Md.

24a. REC'D BY REGISTRAR

DATE JUN 7 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

40 10 1291 25,000

40 10

40 10 1291 25,000

18
FOR STATE
HEALTH DEPT.
M
X
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial.
12
2
VS. 15ME
5M 7/59

Item 20 Film 265 6-28 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06956

1. PLACE OF DEATH

a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen Groves, Maryland
(Brought ashore on the beach at)

c. LENGTH OF STAY IN 1b

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

JOHN

S.

MORRIS

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Sept 14, 1906

9. AGE (In years
last birthday)

53
yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Contractor Eng. Lukens Steel Co-Pa Offnd, N.C.

13. FATHER'S NAME

Joseph A. Morris

14. MOTHER'S MAIDEN NAME

Lizzie Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Jessie Bird Day Morris

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Drowning

850X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

2d. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

2d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell overboard from a runabout boat

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 6/11/60 8:00 PM

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

North East River

Harford

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Wm. J. Tuckers

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
June 16, 1960

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Wm. J. Tuckers & Sons - Belts. Md.

Pt. Co.

23. FUNERAL DIRECTOR

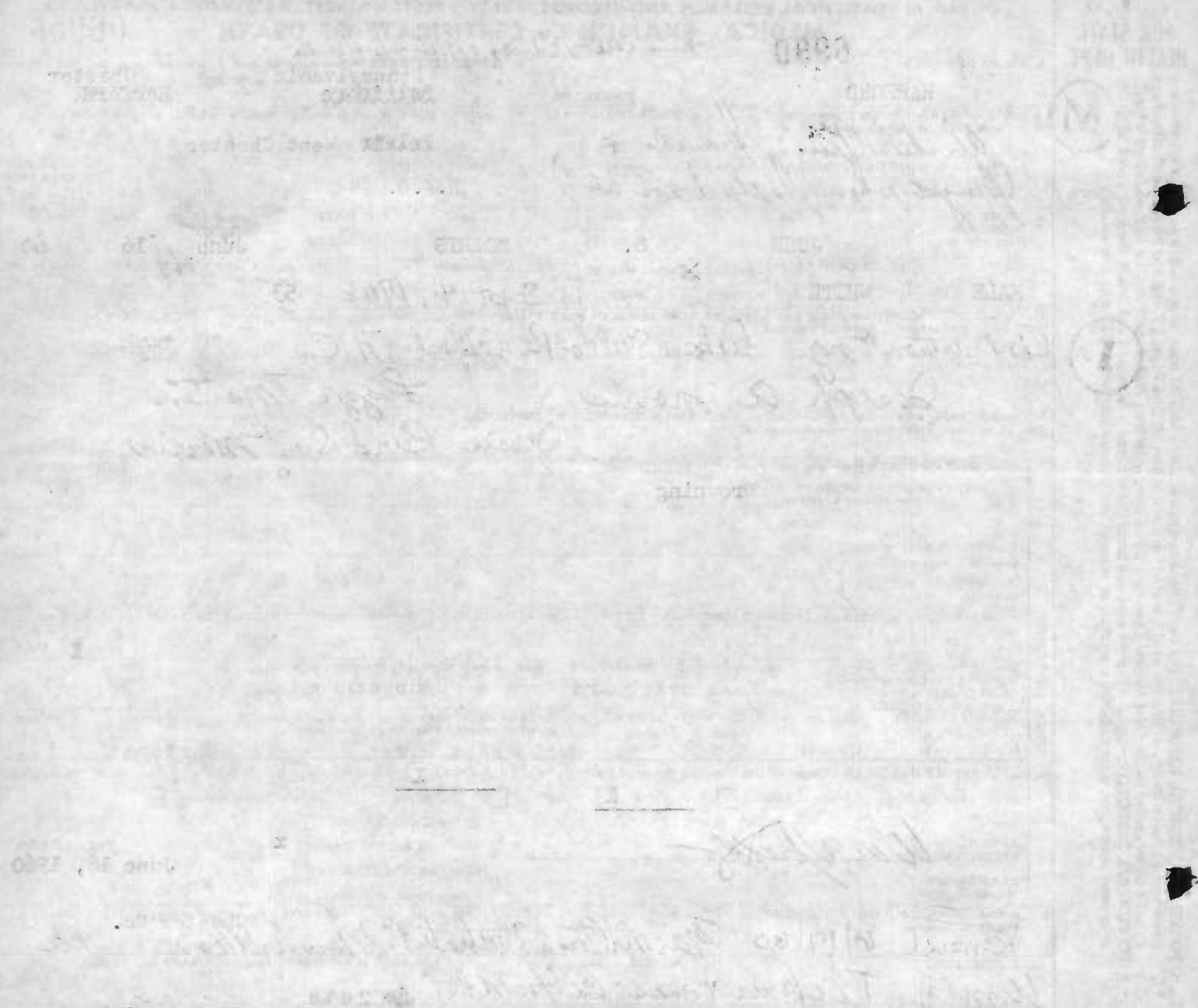
ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE JUN 20 '60

C. Tuckers



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md		b. COUNTY		Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Abingdon		c. LENGTH OF STAY IN 1b		6 mos.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Abingdon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Friends Bar		d. STREET ADDRESS		Friends Bar		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		June 14		Month Day Year		19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years less than 1 year old, write by months)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
F		W				June 4, 1912		48 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Waitress			Tavern			W.Va.			U.S.A.,		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Herman W. Neeley			Tressie K. Marion								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			235-28-6004			L.S. Neeley,			Elkview W.Va.,		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>95W chest</u> INTERVAL BETWEEN ONSET AND DEATH											
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour p.m. 12:15 6-14 1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Friends Bar Abingdon Ha</u>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Gerald C Palmer</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6-14-60 DATE SIGNED								
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bother, Jr.</u>								
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Removal		June 15, 1960		Hafer Funeral Home		Elkview, Kanawha, W.Va.,					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<u>Edward C. Lerner</u>		Abingdon, Md.,		DATE JUN 17 '60		<u>Clifford S. Lerner</u>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06958

Reg. Dist. No.

CERTIFICATE OF DEATH

6992

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE

Md

b. COUNTY

Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Darlington

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Stafford Road

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Darlington

d. STREET ADDRESS

Stafford Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

19 60

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Sept 17 1876

9. AGE (In years
lost birthday)
83 yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewives

13. FATHER'S NAME

Henderson Sheels

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mc

Mo

Avery Pardew

Darlington, Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422-1 Anterior atherosclerotic & Volusire

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 4-1, 19 60, to 6-9, 19 60, that I last saw the deceased alive on 6-6, 19 60, and that death occurred at 4P M, from the causes and on the date stated above.

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, Cremation, Removal (Specify)
June 13 1960

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR
DATE JUN 15 '6024b. REGISTRAR'S SIGNATURE
Cecil S. Farnell

CERTIFICATE OF DATA

100



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	10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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in one event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66959

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plane de Grace c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Mem. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Plane de Grace d. STREET ADDRESS 801 So. Wash. St.									
3. NAME OF DECEASED (Type or print) Harry Jones Reasin		First	Middle	Last	4. DATE OF DEATH June 17 1960	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/1891	9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months 6	11. IF UNDER 24 HRS. <input type="checkbox"/> Days 0	12. Hours 0	13. Year 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRACE FOREMAN US Govt RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HAURE de GRACE Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ALFRED REASIN		14. MOTHER'S MAIDEN NAME REBECCA TOWNSLEY		Address 801 S Washington							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Harry Reasin		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
18a. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		18b. DUE TO Myocardial infarction		18c. INTERVAL BETWEEN ONSET AND DEATH 10 days							
18d. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		18e. (b) DUE TO Coronary arteriosclerosis									
18f. (c)											
19. WAS AUTOPSY PERFORMED? NO		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from 6/13 to 6/17 , 19 60 that (I) (we) last saw the deceased alive on 6/17 , 19 60 and that death occurred at 745M from the causes and on the date stated above.					
22a. SIGNATURE John H. Wallman		22b. DATE SIGNED 6/17/60		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) HAURE de GRACE (County) Md. (State) Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1000 1/2 E. 20th St.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/1960		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL		23d. LOCATION (City, town, or county) HAURE de GRACE (State) Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Connie Johnson, Plane de Grace Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6994

CERTIFICATE OF DEATH

Reg. Dist. No.

06960

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 24		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Pusey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print)	First MALISSA	Middle M.	Last 4. DATE OF DEATH RICHARDSON June 27 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 17, 1898	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jesse E. McMillan		14. MOTHER'S MAIDEN NAME Fannie Dixon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 217-20-4036 Harry L. Richardson, Havre de Grace, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Cerebral Embolism		INTERVAL BETWEEN ONSET AND DEATH 1 day		
(b) DUE TO Normal cardiac Embolism		1 week		
(c) DUE TO Arterios clotic Debris		Arterios clotic Debris		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on June 27, 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Irvin Wachsman, M.D.		ADDRESS (Street, city or town, state) 407 S. Union Ave. DATE SIGNED 6/28/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/60	22c. NAME OF CEMETERY OR CREMATORIAL Center Cemetery	22d. LOCATION (City, town, or county) Nathans Creek, N.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring	ADDRESS Tarring Mineral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Mann
John G. Tarring				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06961

Reg. Dist. No.

CERTIFICATE OF DEATH

6995

1. PLACE OF DEATH
o. COUNTY

HARFORD

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

MARYLAND

b. COUNTY

HARFORD

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

(RURAL) JARRETTSVILLE

c. LENGTH OF STAY IN 1b

12 YRS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

(RURAL) JARRETTSVILLE X

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

RD#1 Rocks, Md

d. STREET ADDRESS

RD#1 Rocks

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHJUNE
Month
1Day
1Year
1960

5. SEX

6. COLOR OR RACE

FEMALE

WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

JULY 17, 1889

9. AGE (In years
lost, birthday)
yrs.

70

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOME MAKER

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN ABSHER

14. MOTHER'S MAIDEN NAME

MARGARET WAGONER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or date of service)

NO

16. SOCIAL SECURITY NO.

213-12-2674

17. INFORMANT

MACGARET RICHARDSON EVERETT, Md
Address: Rocks, Rock

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)352X
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

PNEUMONIA, Lobar

(b) DUE TO

LEFT HEMIPLAEGIA, PARTIAL

(c)

INTERVAL BETWEEN
ONSET AND DEATH

4 DAYS

2 WKS

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 1920d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from MAY 23, 1960, to MAY 31, 1960, that I last saw the deceased
alive on MAY 31, 1960, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Philip W. Heuman M.D.

307 HICKORY

JUNE 4, 1960

PHYSICIAN'S
NAME (Type)

PHILIP W. HEUMAN

BEL AIR, MARYLAND

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Cremation

22b. DATE THEREOF

6/3/1960

22c. NAME OF CEMETERY OR CREMATORI

Bel Air Memorial Gardens

22d. LOCATION (City, town, or county)

Bel Air

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Charles C. Kutz

ADDRESS

Jarrettsville Rd

24a. REC'D BY REGISTRAR

JUN 3 '60

24b. REGISTRAR'S SIGNATURE

Charles C. Kutz

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06962

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Harford (sic)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		d. STREET ADDRESS Rural 07X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Rierson	4. DATE OF DEATH June 5 1960	Month June	Day 5	Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 5 1960	9. AGE (In years last birthday) yrs. —	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours 2	Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Rierson		14. MOTHER'S MAIDEN NAME Nancy Delp						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO.		17. INFORMANT William Rierson		Address Rising Sun, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO 753X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 45 M. from the causes and on the date stated above.								
22a. SIGNATURE Verlinda S. Masella		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 6/6/1960						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/8/1960		23c. NAME OF CEMETERY OR CREMATORIUM Nottingham Cemetery		23d. LOCATION (City, town, or county) Calera		
24. FUNERAL DIRECTOR'S SIGNATURE Verlinda S. Masella		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DATE JUN 9 '60		25b. REGISTRAR'S SIGNATURE Verlinda S. Masella		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6977

CERTIFICATE OF DEATH

Reg. Dist. No. 06963

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen (Rural)		d. STREET ADDRESS R.D. #2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First LOUIS	Middle C	Lost SCHANTZ	4. DATE OF DEATH June	Month 6	Day 19	Year 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 9, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		10b. KIND OF BUSINESS OR INDUSTRY Auto Garage		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME John George Schantz		14. MOTHER'S MAIDEN NAME May F. Reauter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-2962		17. INFORMANT Helen M. Schantz, Aberdeen, Md.		Address R.D. #2 Aberdeen, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bel Air, Md.		(County) (State)
21. I certify that I attended the deceased from <u>6 June</u> , 1960, to <u>6 June</u> , 1960, that I last saw the deceased alive on <u>6 June</u> , 1960, and that death occurred at <u>12:01 PM</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Bel Air, Md.		
ACTUAL SIGNATURE Charles Richardson Jr. M.D.						DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORIAL Bakers Cemetery		22d. LOCATION (City, town, or county) R.D. 2, Aberdeen, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
John G. Tarring								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6978

CERTIFICATE OF DEATH

Reg. Dist. No.

06964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE		c. LENGTH OF STAY IN lb 1 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN			
d. STREET ADDRESS 07X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAULINE		First MIDDLE SHMEL	4. DATE OF DEATH JUNE Month 30 Day Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1888		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		
13. FATHER'S NAME MICHAEL DEMICK		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MICHAEL SHMEL Address RISING SUN, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-00 DUE TO <i>Myocardial infarction</i> 3 hours. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Arteriosclerotic heart disease</i> 8 years DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6/10</u> , 1960, to <u>6/30</u> , 1960, that I last saw the deceased alive on <u>6/30</u> , 1960, and that death occurred at <u>7P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Neil Taylor</u> M.D. ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>7/1/60</u> PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u> Rising Sun, Md 7/1/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 3, 1960	22c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEM.	22d. LOCATION (City, town, or county) MARTFORD	(State) CONN.
23. FUNERAL DIRECTOR'S SIGNATURE Hermione E. McMullen		ADDRESS Rising Sun, Md	24a. REC'D. BY REGISTRAR JUL 5 1960 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6979

CERTIFICATE OF DEATH

Reg. Dist. No. 06965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>about 34 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>653 St. Clair St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 St. Havre de Grace</i>	
3. NAME OF DECEASED (Type or print) <i>Sarah</i>		First <i>E.</i>	Middle <i>Smith</i>
4. DATE OF DEATH Month <i>6</i>		Month <i>14</i>	Day Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-1909</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beautician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beauty Culture</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>George H. Hoke</i>	
14. MOTHER'S MAIDEN NAME <i>Maggie Kell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>218-32-4130</i>		INFORMANT <i>Mrs. Margaret Hoke, Havre de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.</i>		INTERVAL BETWEEN ONSET AND DEATH Day of Death	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
(c) <i>Hypertensive-Arteriosclerotic Heart disease</i>		6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January</i> , 19 <i>60</i> , to <i>June 14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 14</i> , 19 <i>60</i> , and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>George T. Stansbury, M.D. 569 Revolution Street</i> <i>6/15/60</i>			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-18-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Union Methodist Cem.</i>
22d. LOCATION (City, town, or county) <i>Aberdeen, Harford Co., Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otis J. Bullock, Havre de Grace, Md.</i>		24a. REC'D BY REGISTRAR ADDRESS <i>550 Lewis St.</i> DATE <i>JUN 17 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Thane</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6980

CERTIFICATE OF DEATH

06966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 6 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First J.	Middle J. Last SMITHSON
4. DATE OF DEATH JUNE 5 1960		Month JUNE	Day 5
5. SEX M.		6. COLOR OR RACE Wht.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1/23/00		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SLATE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JAMES SMITHSON		14. MOTHER'S MAIDEN NAME OLIVIA SMITHSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 184-05-1577	
17. INFORMANT E. R. JONES		Address (SAME AS ABOVE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 576X <i>Peritonitis, edema, unknown.</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Edema, unknown. Caudate degeneration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/31 , 1960, to 6/5 , 1960, that I last saw the deceased alive on 6/5 , 1960, and that death occurred at 12:45 M, from the causes and on the date stated above. <i>John K. Hunter</i>			
ACTUAL SIGNATURE W. K. GREENE		ADDRESS (Street, city or town, state) HARFORD Mem. Hosp.	
PHYSICIAN'S NAME (Type) J. KHALATBACH		DATE SIGNED 6/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-8-60	
22c. NAME OF CEMETERY OR CREMATORIAL SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Hartman, Delta, Pa.</i>		24a. REC'D BY REGISTRAR DATE SUN 8 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CHRONICLES OF DEATH

0303

WINTER 1940
PEACEFUL VALLEY

1940

01

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4
M
07
I
0
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6981 CERTIFICATE OF DEATH

0696

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUVE DE GRACE		b. COUNTY HARFORD	
c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hau de Grace, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		d. STREET ADDRESS 516 N. Adams	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WARNER C. A. TAYLOR		First	Middle
		Last	
4. DATE OF DEATH JUNE 27 1960		Month	Day
		Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Aug. 25 1873	
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Retired	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE WENNER B. Taylor		14. MOTHER'S MAIDEN NAME MARY Ann Hague	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Unknown		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1777X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Ca. of prostate	
		DUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ca. of prostate	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/27/60
20f. (City or town) Edgewater		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from June 19th 1960 to June 27th 1960 that (I) (we) last saw the deceased alive on June 27 1960 and that death occurred at 10M , from the causes and on the date stated above.		22b. DATE SIGNED 6/27/60	
22a. SIGNATURE Edward C. Loo, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS 211 N. Union Ave. Hau de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6/30/60		23c. NAME OF CEMETERY OR CREMATORIAL Elstton	
23b. DATE THEREOF 6/30/60		23d. LOCATION (City, town, or county) Elstton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James J. Dr. Hau de Grace, Md.		25a. REC'D BY REGISTRAR DATE 1 '60	25b. REGISTRAR'S SIGNATURE Carroll S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06968

Reg. Dist. No.

1.		PLACE OF DEATH a. COUNTY		6982 Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE PC b. COUNTY ✓		
		Harde Grace				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		47X-3		
		HARFORD MEMORIAL HOSPITAL		950 Mississippi Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
M		W	Elvin	Walter	June 10			1960
5. SEX		6. COLOR OF RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
				JANUARY 14, 1920		40 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
MUSICIAN		ENTERTAINMENT		NEW YORK		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
HARRY WARSHAWSKY		ROSE LOSIKOFF						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		133-079-974		SIDNEY RAPKE		BETHESDA MD. 6304 E. HALBERT RD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Crushing injury Chest						
816X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
		A into accident auto auto type						
20c. TIME OF INJURY Hour		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
1201 p.m.		6-10 1960						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE		Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 138 Ave, Jr		DATE SIGNED		
EXAMINER'S NAME (Type)		Gerald C Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6-10-60		
22a. BURIAL, CREMATION, REMOVAL (specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
BURIAL		JUNE 12, 1960		KING DAVID MEMORIAL GARDEN		FALLS CHURCH		Va.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
B Dargatz & Son		3501-14 N. NW		DATE JUN 14 '60		O. L. H. S. K. H. A.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your records. To FUNERAL DIRECTOR: Page 3 should be used as a burial and transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

66969

1. PLACE OF DEATH a. COUNTY <i>HARFORD</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE DE GRACE</i>		c. LENGTH OF STAY IN 1b <i>14 yrs.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HARFORD MEMORIAL Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>ENR</i>	Middle <i>EMANUEL</i>	Last <i>Weaver</i>				
4. DATE OF DEATH <i>June 27 1960</i>	Month <i>June</i>	Day <i>27</i>	Year <i>1960</i>				
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/14/03</i>				
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>56 yrs.</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DISABLED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>					
11. BIRTHPLACE (State or foreign country) <i>PENN.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Emmanuel M. Weaver</i>		14. MOTHER'S MAIDEN NAME <i>Alberta Regel</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>W.W. 2</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>					
17. INFORMANT <i>Betty J. Weaver</i>		Address <i>JAME.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Adema</i>							
DUE TO <i>420.1</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary Occlusion</i>							
DUE TO (c) <i>Myocardial infarction</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pseudotumor</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>None</i>	(County) <i>None</i>
21. I certify that (I) (this hospital) attended the deceased from <i>June 1 1960</i> to <i>June 27 1960</i> , that (I) (we) last saw the deceased alive on <i>June 2 1960</i> , and that death occurred at <i>12:30 M.</i> from the causes and on the date stated above.				22. DATE SIGNED <i>6/27/60</i>			
22a. SIGNATURE <i>John H. Wachman</i>				22b. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>Levin N. Wachman</i>				23. BURIAL / CREMATION, INSTITUTION (Specify) <i>6/30/60</i>			
23b. DATE THEREOF <i>6/30/60</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Hoffman</i>			
23d. LOCATION (City, town, or county) <i>New Bunkberg Pa.</i>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Hoffman, Hanover, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JUN 28 '60</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur J. Hoffman</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF TEXAS
AUG 10 1940 1940

2323



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06970

6984

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hause de Grace

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

104 Harford Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Wilkinson

Last

Ira E. Wilkinson

4. DATE
OF
DEATH

Month

Day

Year

YES NO

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER-MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

March 19 1888

62

Yrs.

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

laborer foreman

10b. KIND OF BUSINESS OR INDUSTRY

lumber Brown

11. BIRTHPLACE (State or foreign country)

Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Walter Wilkinson

14. MOTHER'S MAREN NAME

Ida Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

If yes, give rank or dates of service)

16. SOCIAL SECURITY NO.

819-01-6545

17. INFORMANT

Mr. Ira Wilkinson

Address

Grace

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

0

19

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.

20d. INJURY OCCURRED
While Not while
of work of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Ira C. Palmer

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6-22-60

22a. BURIAL OR CREMATION, DATE THEREOF
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

JUN 28 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6985

CERTIFICATE OF DEATH

06985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the hospital, or removal, and in any event, within 72 hours after death.

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore		Baltimore		3 days & 12 hrs.		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)		d. STREET ADDRESS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Mayfield Memorial Hospital		49 So. Main St.		Port Deposit		07X-2	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year
Pauline		Will		June	22	1960	
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
Female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2-12-1888	72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Lawwife				Md.		U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
? Brauer		— Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		219-34-0563		Meriel Jackson - Perryville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Vascul. - Accident				36 hrs.	
443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Hypertension, Rad. Vascul. disease				10 yrs.	
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19							
21. I certify that (I) (this hospital) attended the deceased from 5-12-60 to June 22, 1960, that (I) (we) last saw the deceased alive on 5-12-60, and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		G.H. Richards Jr. M.D.		Port Deposit, Md.			
23a. BURIAL, CREMATION, REBURN (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) (State)	
Burial		6-24-1960		West Nottingham Cem.		Colona, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Meriel Patterson, Jr.		Perryville, Md.		JUN 24 '60		Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06972

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air,		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Cora		First	Middle	Last	4. DATE OF DEATH June	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 14, 1868	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Harvey Pennington		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mo		17. INFORMANT Arthur C. Ashley		Address Bel Air, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Chronic Cardio-vascular disease		DUE TO —		DUE TO —		INTERVAL BETWEEN ONSET AND DEATH 3 days		
DUE TO —		(c)				?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Forest Hill, Md.	(County)	(State)		
21. I certify that I attended the deceased from June 19, 1950, to June 9, 1960, that I last saw the deceased alive on June 9, 1960, and that death occurred at 8:45 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Forest Hill, Md.						DATE SIGNED		
ACTUAL SIGNATURE Willard P. Hudson M.D.								
PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) June 19, 1960, at Smithport M.C.		22b. DATE THEREOF JUN 14 '60		22d. LOCATION (City, town, or county) M.C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey Harlington, Md.		ADDRESS		24a. REC'D BY REGISTRAR JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06973

6996

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		d. STREET ADDRESS d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								
3. NAME OF DECEASED (Type or print)		First Lida	Middle M.	Last Willis	4. DATE OF DEATH	Month June	Day 27	Year 19 60
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Churchville, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,		
13. FATHER'S NAME William A. Bodt				14. MOTHER'S MAIDEN NAME Annie Preston				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Levering O. Willis		Address Abingdon Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gangrene left lower leg</i> DUE TO <i>years</i> INTERVAL BETWEEN ONSET AND DEATH 1 month. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arterial sclerosis - hemiplegia</i> DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		Month June	Day Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Edgewood	(County) Maryland	(State) Md.
21. I certify that I attended the deceased from <i>April 15, 1960</i> , to <i>June 27, 1960</i> , that I last saw the deceased alive on <i>June 27, 1960</i> , and that death occurred at <i>745 P. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edgewood Maryland.								
ACTUAL SIGNATURE <i>Fred O. Hodus</i>	M.D.		DATE SIGNED Edgewood Maryland.					
PHYSICIAN'S NAME (Type) <i>Fred O. Hodus</i>	Edgewood Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 30, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Smith's Chapel	22d. LOCATION (City, town, or county) Churchville Harford Md.,					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard W. Brown Jr.</i>	ADDRESS Abingdon, Md.	24a. REC'D BY REGISTRAR DATE JUL 5 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6986

CERTIFICATE OF DEATH

06974

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Harford MARYLAND		Delaware b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haven de Grace DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 300 E. 25th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE Month Day Year June 25, 1960	
3. NAME OF DECEASED (Type or print)		First Gabrella	Middle Henn
4. DATE OF DEATH		Lost	Month Day Year
5. SEX Female Negro		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 12, 1877		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Bayview, Maryland U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Ray	
14. MOTHER'S MAIDEN NAME Ester Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Robert C. Winn, Jr. Haven de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Cardiac Myo-Pathosis Carotid Vascular Disease Chronic Disease Refractory	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> 19 <u>60</u> to <u>6-17</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> 19 <u>60</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.		22b. DATE SIGNED 6/26/60	
22c. PHYSICIAN'S NAME (Type) Elmer E. Bullock		22d. ADDRESS Haven de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1960	
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Baptist Cem.		23d. LOCATION (City, town, or county) North East, Cecil C. Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock		ADDRESS 556 Lewis St.	
		25a. REC'D BY REGISTRAR DATE JUN 29 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

БІЛОРУСЬКІ ТВЕРДІ АДОБАТІ ПИЛУГАМІ

ІДАЕВСЬКІ ПАРНИКИ

2623



TO DEATH: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained for your files.
 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 3 should be used as a burial/transit permit. Fill pages 1 and 2 with the State Board of Health, within 72 hours after death.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

699 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06975

1. PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

White Hall

c. LENGTH OF STAY IN 1b

34 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RD

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

W

a. MARRIED b. NEVER MARRIED

c. WIDOWED d. DIVORCED

B. DATE OF BIRTH

7-22-1888

9. AGE (In years
last birthday)

71

IF UNDER 1 YEAR
Months

0

IF UNDER 24 HRS.
Hours

0

Min.

0

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

OWN FARM

11. BIRTHPLACE (State or foreign country)

HARFORD Co., MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM A. WRIGHT

14. MOTHER'S MAIDEN NAME

R. VIRGINIA BULL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-36-0459

17. INFORMANT

W.K Wright Pyburne Rd. Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

422.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

CHIEF MEDICAL EXAMINER B. Palmer, M.D.

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

6-28-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

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NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

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(State)

Funeral

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Funeral

7-30-60

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NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

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NORRISVILLE, HARFORD Co., MD.

(State)

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7-30-60

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NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

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(State)

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7-30-60

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NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

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NORRISVILLE, HARFORD Co., MD.

(State)

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ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

Funeral

7-30-60

ST. PAUL METH.

NORRISVILLE, HARFORD Co., MD.

(State)

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